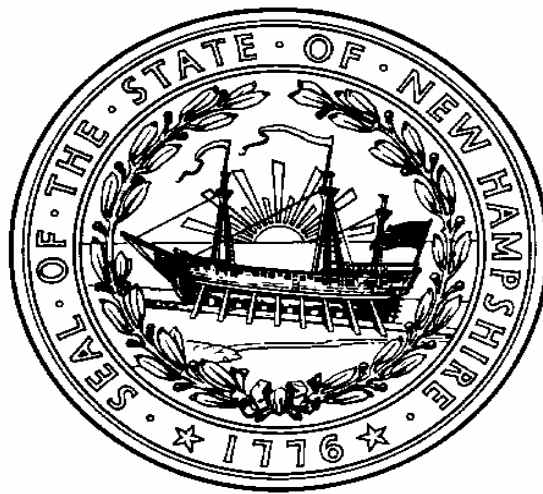

Dental Plan Description

State of New Hampshire Retirees Group 1777





One Delta Drive
PO Box 2002
Concord, NH 03302-2002
Customer Service:
603-223-1234
800-832-5700



**Outline of Benefits
State of New Hampshire
Group Number: 1777
(Retirees)**

Plan Year - January 1 through December 31.

Eligibility Period - State of New Hampshire eligibility rules apply.

Waiting Period –

Coverage B – First day of the month following 6 months of continuous coverage.

Coverage C – First day of the month following 12 months of continuous coverage.

Waiting periods may apply to late entrant enrollees.

Eligible Persons – Retirees, their spouses and dependent children are covered under this plan. A child will be covered on the first of the month following their 2nd birthday and may remain covered until their 19th birthday (end of the month); unmarried dependent children who are full-time students are covered until their 25th birthday (end of the month).

Selected Benefits & Percentages Paid by Northeast Delta Dental -

Coverage A - Diagnostic & Preventive	100%
Coverage B - Basic	80%
Coverage C – Major	50%

Maximum Benefit - The maximum amount which your plan will pay is \$1000 per person per Plan Year.

Deductible - There is a \$25 deductible per person per Plan Year, Applied to Coverage C services only. Any expense incurred during the last 3 months of a calendar year which is applied against an individual's deductible will also reduce his/her deductible for the next year.

Contribution – The retiree will be responsible for the entire cost of the program.

Benefit percentages shown are based upon the actual charge submitted to a maximum of the participating dentist's approved fees or Northeast Delta Dental's allowance for nonparticipating dentists.

OOB3/06

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Northeast Delta Dental welcomes you to the growing number of people receiving benefits through our Dental Care programs.

This booklet describes the benefits of your program and tells you how to use your plan. Please read it carefully to understand the benefits and provisions of your Delta Dental Plan. But, before you turn the page, we'd like you to know something about us...

- Delta Dental is a not-for-profit organization established and supported by Dentists to make Dental Care more available to the general public.
- Delta Dental is affiliated with a national association known as Delta Dental Plans Association (DDPA), which provides Dental Care programs in all states and U.S. territories.
- A substantial majority of Dentists in Maine, New Hampshire, and Vermont participate in Delta Dental through Participating Dentist Agreements.

You are encouraged to take advantage of your Delta Dental Plan, since good oral health is an important part of your overall general health. You are also encouraged to obtain your Dental Care from a Participating Dentist to get the best value from your program.

I. Definitions

1. **Agreement** - the contract between your group and Delta Dental to provide dental benefits to Eligible Persons.
2. **Contract Holder** - the group named in the application.
3. **Co-payment** - the amount of the Dental Care cost that you are required to pay.
4. **Coverage** - the Dental Care referred to in the Agreement.
5. **Coverage Period** - the length of time for which you are eligible to receive benefits as specified in the Outline of Benefits.
6. **DDPA (Delta Dental Plan Association)** - the Association which is made up of all the Delta Dental Plans and affiliated organizations operating in the United States and its territories.
7. **Deductible** - the portion of the charge for covered Dental Care that the Subscriber or Eligible Dependent must pay before Delta Dental's liability begins.
8. **Delta Dental** - the Delta Dental Plans in Maine, New Hampshire, and Vermont, collectively known as Northeast Delta Dental.
9. **Dental Care** - dental services ordinarily provided by licensed Dentists for diagnosis or treatment of dental disease, injury, or abnormality based on valid dental need in accordance with accepted standards of dental practice at the time the service is rendered.
10. **Dental Plan Description** - this document. The Dental Plan Description together with the Agreement form the terms and conditions under which Delta Dental shall administer your dental benefit program.
11. **Dentist** - a person duly licensed to practice dentistry in the state in which the Dental Care is provided.

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12. **Dependent :**
 - a. The spouse to whom the Subscriber is legally married; and/or
 - b. children of the Subscriber by natural birth, legal adoption or in the process of adoption, guardianship, and/or stepchildren; provided such children are unmarried, are not in military service, and are the Subscriber's Dependents for federal income tax purposes unless there is a court decree which awards the dependency exemption(s) to the non-covered parent.
 13. **Eligible Dependents** - those Dependents who meet the eligibility requirements of the Agreement and are enrolled by Subscribers in the group's benefit program.
 14. **Eligible Persons** - the Subscriber and Dependent(s).
 15. **Maximum** - the dollar amount Delta Dental will pay in any Coverage Period for covered benefits.
 16. **Non-Participating Dentist** - a Dentist who has not signed a Participating Dentist Agreement.
 17. **Outline of Benefits** - the insert to this booklet which describes your dental benefits.
 18. **Participating Dentist** - a Dentist whose fees are filed with and/or accepted by Delta Dental and who has signed a Participating Agreement. A Participating Dentist shall abide by such uniform rules and regulations as are from time to time prescribed by Delta Dental.
 19. **Predetermination** - an administrative procedure where the Dentist submits the treatment plan to Delta Dental in advance of performing dental services. Delta Dental recommends that you ask your Dentist to request Predetermination of proposed services that are considered to be other than brief or routine. Predetermination provides an estimate of what Delta Dental will pay for the services, which helps avoid confusion and misunderstanding between you and your Dentist.
 20. **Processing Policies** - policies approved by Delta Dental, as may be amended from time to time, to be used in processing treatment plans for Predetermination and for payment.
 21. **Subscriber** - any person who:
 - a. rendered service to the Contract Holder as a paid employee, and
 - b. is certified as being eligible by the Contract Holder as a member of the group specified in the application, and
 - c. enrolls in the group's benefit program.

II. How to File a Claim

To Use Your Plan Follow These Steps:

Please read this Dental Plan Description carefully to familiarize yourself with the benefits and provisions of your dental plan.

You are assured of receiving full benefits under this dental plan if you visit a Participating Dentist (ask your dentist if he/she participates with Delta Dental or visit the Northeast Delta Dental website at www.nedelta.com).

When you visit your dental office, inform them that you are covered under a Delta Dental program and show your identification card. Your Dentist will perform an evaluation and plan the course of treatment. When the treatment has been completed, the claim form will be sent to Delta Dental for payment for covered services.

Participating Dentists will have claim forms available in their offices. A Participating Dentist will not charge at the time of treatment for covered services, but may request payment for non-covered services, Deductibles, or Co-payment. Delta Dental will pay the Participating Dentist directly and send a Notification of Benefits form to you which will indicate the amount you should pay, if any, to your Dentist.

Delta Dental provides coverage regardless of the patient's choice of dentists, participating or not. When visiting a nonparticipating dentist within the Northeast Delta Dental operating area of Maine, New Hampshire and Vermont, payment for services rendered will be based on the lesser of the dentist's actual submitted charge or the Plan's allowance for nonparticipating dentists. The patient may be required to submit the claim directly and pay for the services at the time they are provided. The Notification of Benefits and the claim payment will go to the subscriber; the patient will be responsible for any remaining balance.

When visiting a nonparticipating dentist outside the Northeast Delta Dental operating area, payment for services rendered will be based on the lesser of the dentist's actual submitted charge or an amount equal to a selected percentile of a nationally-recognized database for the area in which the services were provided. The patient may be required to submit the claim directly and pay for the services at the time they are provided; the patient will be responsible for any remaining balance. The Notification of Benefits will go to the subscriber. The claim payment will go to the dentist unless the claim is marked "paid," otherwise it will be sent to the subscriber.

Predetermination of Benefits:

Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid any potential confusion regarding Delta Dental's payment and your financial obligation to the Dentist.

Please note that Predetermination does NOT guarantee payment. Rather, Predetermination is an estimate of benefits based on your current benefits. A new Coverage Period and/or contract change may alter the final payment, because payment is based on information on file at the time treatment is provided (the date of service). Any changes in a Dentist's fee schedule or participating status may also affect Delta Dental's final payment.

The Predetermination Voucher reflects your benefits based on the procedures and costs submitted by your dental office. Questions concerning Predetermination should be directed to Delta Dental's Customer Service department at 800-832-5700 or 603-223-1234.

III. Benefits

Coverage A (Diagnostic & Preventive) Benefits

- Diagnostic:** Evaluations to determine required dental treatment
- Limited oral evaluation
- Comprehensive oral evaluation - one complete comprehensive evaluation per specialist or general Dentist in a lifetime
- Periodic evaluation - once in any period of six (6) consecutive months. This can be by a specialist or a general Dentist.
- Preventive:** Specific procedures employed to prevent the occurrence of dental disease
- Prophylaxis (cleaning) - once in any period of six (6) consecutive months (child prophylaxis up to thirteenth (13) birthday; adult prophylaxis thereafter). This can be a routine prophylaxis or a full mouth debridement (Coverage A), or periodontal maintenance (Coverage B).
- Fluoride treatment - once in any period of twelve (12) consecutive months up to eighteenth (18) birthday
- Space Maintainers
- Sealants

NOTE: *The time limitation will be measured from the date the service was last performed.*

Coverage A Exclusions and Limitations:

1. A prophylaxis, a full mouth debridement, or periodontal maintenance procedures is essentially a duplication of services when provided on the same day of treatment as periodontal scaling and root planing. Payment is made accordingly and a separate fee may not be charged by Participating Dentists.
2. Sealant benefit limitation:
 - a. Sealant benefit is provided only to Eligible Dependents fourteen (14) years or younger.
 - b. Sealant benefit includes the application of sealants to caries-free (no decay) permanent molars.
 - c. Sealant benefit is provided no more than once in a lifetime per tooth.
3. A limited oral evaluation, when done in conjunction with a procedure (other than radiographs) on the same visit is considered a part of, and included in the fee for, the procedure. A separate fee may not be charged by Participating Dentists.
4. The replacement or repair of space maintainers is not a covered benefit.
5. Space maintainers are a covered benefit for Eligible Dependents fifteen (15) years or younger when a space is being maintained for an erupting permanent tooth.

Coverage B (Basic) Benefits

Diagnostic:	Radiographs (x-rays) - complete series or panoramic film once in any period of three (3) consecutive years; bitewing films (x-rays) once in any period of six (6) consecutive months; films (x-rays) of individual teeth as necessary
Palliative Treatment:	Minor emergency treatment for the relief of pain
Restorative:	Amalgam (silver) and/or resin (white) restorations (fillings). Resin restorations are a benefit on anterior teeth only.
Endodontics:	Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy
Periodontics:	Treatment of diseased tissue supporting the teeth and periodontal maintenance procedures Prophylaxis (cleaning) - once (1) in any period of six (6) consecutive months. This can be a routine prophylaxis or a full mouth debridement (Coverage A) or periodontal maintenance procedures (Coverage B).
Oral Surgery:	Extractions and covered surgical procedures
Injection Drugs	
Denture Repair:	Repair of removable complete or partial denture to its original condition
Denture Rebase And Reline:	Rebase and reline of complete and partial dentures
Crown and Fixed Partial Denture Repair:	Repair of crown or fixed partial denture to its original condition
Anesthesia:	General anesthesia administered in conjunction with an extraction; tooth reimplantation; surgical exposure of tooth; biopsy; transseptal fiberotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy; and/or frenuloplasty. General anesthesia will also be covered when administered in conjunction with procedures performed in the dental office for the following covered patients: <ul style="list-style-type: none">(a) A child under the age of six (6) who is determined by a licensed Dentist in conjunction with a licensed primary care physician to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such condition; or(b) A person who has exceptional medical circumstances or a developmental disability as determined by a licensed physician which place the person at serious risk.

NOTE: *The time limitation will be measured from the date the service was last performed.*

Coverage B Exclusions and Limitations:

1. A prophylaxis, a full mouth debridement, or periodontal maintenance procedures is essentially a duplication of services when provided on the same day of treatment as periodontal scaling and root planing. Payment is made accordingly and a separate fee may not be charged by Participating Dentists.
2. A panoramic film, with or without accompanying bitewings, is considered the same as a complete series and is paid as such.

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3. Payment for additional periapical radiographs within a thirty-day (30-day) period of a complete series or panoramic film, unless there is evidence of trauma, is subject to consultants' review. A separate fee may not be charged by Participating Dentists.
 4. Tooth preparation, bases, impressions, and local anesthesia, or other services that are part of the complete dental procedure, are considered components of, and included in the fee for, a complete procedure. A separate fee may not be charged by Participating Dentists.
 5. Resin restorations in posterior teeth (white fillings in bicuspid and molars) are optional. An allowance will be paid equal to an amalgam restoration. If performed, patient is responsible for additional fee.
 6. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A separate fee may not be charged by Participating Dentists.
 7. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A separate fee may not be charged by Participating Dentists.
 8. Periodontal scaling and root planing is a covered benefit per quadrant once in any period of twelve (12) consecutive months.
 9. Exploratory surgical services are not a covered benefit. Patient is financially responsible.
 10. An adjustment will be made for two (2) or more surfaces that are normally joined together. A separate fee may not be charged by Participating Dentists.
 11. Root canal therapy on a tooth is a benefit once in any period of three (3) consecutive years.
 12. Periodontal services are a non-covered benefit when done for crown lengthening.
 13. An indirect pulp cap, when rendered at the same time as the final restoration, is considered a base and is not a benefit when billed as a separate procedure in conjunction with the final restoration. A separate fee may not be charged by Participating Dentists.
 14. Recementation of a crown, inlay, onlay, partial coverage restoration, and/or fixed partial denture is a benefit once in any period of twelve (12) consecutive months.
 15. Repairs to crowns and fixed partial dentures are a benefit once in any period of five (5) consecutive years.
 16. Anterior deciduous root canal therapy is not a covered benefit.
 17. Gingivectomy, gingival flap procedure, osseous surgery, bone replacement graft, distal wedge, or soft tissue graft procedure is a benefit once in any period of three (3) consecutive years.
 18. One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in any period of five (5) consecutive years.
 19. The relining of a denture is a benefit once in any period of three (3) consecutive years.
 20. Recementation of a cast or prefabricated post and core is a benefit once in any period of twelve (12) consecutive months.

Please note: Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid any potential confusion regarding Delta Dental's payment and your financial obligation to the Dentist.

Coverage C (Major) Benefits

Restorative Crowns and Onlays: Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations

Prosthodontics: Fixed partial dentures (abutment crowns and pontics); removable complete and partial dentures; core buildups; cast and prefabricated post and cores; and precision attachments.

Implant Supported Prosthetics

NOTE: *The time limitation will be measured from the date the service was last performed.*

Coverage C Exclusions and Limitations:

1. Onlays, or crowns made of resin-based composite, porcelain, porcelain fused to metal, full cast metal, or resin fused to metal, where the metal is high noble metal, titanium, noble metal or predominantly base metal, are not benefits for Eligible Dependents under the age of twelve (12).
2. Tissue conditioning is not a covered benefit.
3. Coverage C benefit limitations:
 - a. One (1) complete maxillary (upper) and one (1) complete mandibular (lower) denture in any period of five (5) consecutive years.
 - b. A removable or fixed partial denture in any period of five (5) consecutive years unless the loss of additional teeth requires the construction of a new appliance.
 - c. Crowns, onlays, core buildups, and post and cores are a benefit once per tooth in any period of five (5) consecutive years.
 - d. The period of five (5) consecutive years referred to in (a), (b), and (c) above is to be measured from the date the service was last performed.
4. Removable or fixed partial dentures are not benefits for patients under the age of twelve (12).
5. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area is a covered benefit. Patient will be responsible for any additional fee.

Please note: Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid any potential confusion regarding Delta Dental's payment and your financial obligation to the Dentist.

IV. General Exclusions and Limitations

1. The dental benefits provided by Delta Dental shall not include the following:
 - a. Services for injuries or conditions compensable under Worker's Compensation or Employer's Liability laws.
 - b. Services that are determined by Delta Dental to be rendered for cosmetic reasons, or to correct congenital malformations, or cosmetic surgery. (This exclusion is not intended to exclude services provided to newborn children for congenital defects or birth abnormalities.)
 - c. Services including, but not limited to, endodontics and prosthodontics (including restorative crowns and removable and fixed dentures), started prior to the date the Subscriber or Eligible Dependent became eligible under the Agreement.
 - d. Prescription drugs, premedications, and/or relative analgesia.
 - e. Charges for hospitalization, general anesthesia for restorative dentistry (except as noted in Section III. Coverage B Benefits), preventive control programs, periodontal splinting, myofunctional therapy, treatment of temporomandibular joint (TMJ) dysfunction and related diagnostic procedures, equilibration, and gnathological reporting.
 - f. Charges for failure to keep a scheduled visit with the Dentist.
 - g. Charges for completion of forms. Such charges shall not be made to a Subscriber or Eligible Dependent by Participating Dentists.
 - h. Dental Care that is not necessary and customary as determined by generally accepted dental practice standards.
 - i. Dental Care or supplies that are not within the classification of benefits defined in the Agreement.
 - j. Appliances, procedures, or restorations for: (a) increasing vertical dimension; (b) altering, restoring, or maintaining occlusion; (c) replacing tooth structure lost by attrition or abrasion; (d) correcting congenital or developmental malformations; (e) esthetic purposes; or (f) implantology techniques.
 - k. Payments of benefits for the Subscriber and/or Eligible Dependent(s) terminate on the last day of the month after the date on which the Subscriber becomes ineligible for benefits.
 - l. Charges for Dental Care or supplies for which no charge would have been made in the absence of dental benefits.
 - m. Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to act of war, declared or undeclared.
 - n. All orthodontic services, including evaluations and radiographs, are not covered benefits. If services are rendered they should be done so with the agreement of the patient to assume additional cost.
 - o. Temporary services.
 - p. A consultation unless performed by a practitioner who is not performing further services.
 - q. Case presentation and treatment planning. Patient will be responsible for any additional fee.
 - r. Athletic mouthguards and occlusal guards (night guards).
 - s. Pulp vitality tests.
 - t. Incomplete treatment.

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2. The dental benefits provided by Delta Dental shall be limited as follows:
- a. Dental Care rendered by other than a Dentist shall not be a benefit, except that scaling or cleaning of teeth and topical application of fluoride and such other treatment performed by a licensed dental hygienist shall be a benefit, so long as the treatment is rendered under the supervision and guidance of a Dentist, in accordance with generally accepted dental practice standards.
 - b. Optional Dental Care: In all cases in which the Subscriber or Eligible Dependent selects more expensive Dental Care than is customarily provided, Delta Dental will pay the selected Co-payment for the Dental Care which is customarily provided to restore the tooth to contour and function. The Subscriber or Eligible Dependent shall be responsible for the remainder of the Dentist's fee.
 - c. Predetermination does not guarantee payment. Payment is based upon eligibility, benefits selected by the group, and allowable charges at the time the Dental Care is rendered. If Coordination of Benefits is involved, the amount of payment is subject to change dramatically pending payment by primary carrier.
 - d. Services completed or in progress at the Subscriber's or Eligible Dependent's date of death will be paid in full to the limit of Delta Dental's liability.
 - e. When services for Dental Care in progress are interrupted and completed thereafter by another Dentist, Delta Dental will review the claim to determine the payment, if any, due each Dentist.
 - f. Maximum Payment:
 - (i) The Maximum amount payable in any Coverage Period, or any portion thereof, shall be limited to the amount specified in the Outline of Benefits.
 - (ii) Delta Dental's payment shall be reduced by any Deductible.
 - g. Specialized techniques including, but not limited to: implantology, overdentures and procedures associated therewith, and personalization or characterization, are excluded. Patient will be responsible for part or all of the fee for these services.
 - h. Diagnostic models/photographs are not a covered benefit.
 - i. Delta Dental programs provide amalgam (silver) or resin (white) restorations for treatment of caries. If the teeth can be restored with such materials, any gold restorations, crowns, inlays, or onlays are considered optional. Patient will be responsible for additional fee.
 - j. A claim (or satisfactory written proof acceptable to Delta Dental) must be furnished to Delta Dental at its principal office within twenty-four (24) months from the date the Dentist provided Dental Care. No payment will be made on a claim with dates of service in excess of the twenty-four (24) month limitation.

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- k. The Date of Incurred Liability refers to the date a service is subject to the applicable Deductible, Co-payment percentage, Maximum benefit, and limitations. The total cost of the service is applied to the Coverage Period during which the service is incurred, irrespective of the Coverage Period in which the service is completed. To be considered for a benefit determination, multiple visit procedures must be completed.

Delta Dental's date of incurred liability for multiple visit procedures is as follows:

- (i) Restorative Crowns - Total cost for crowns and onlays shall be incurred on the date that the tooth is prepared.
- (ii) Fixed Partial Dentures (abutment crowns and pontics) - The total cost for fixed partial dentures shall be incurred on the date that the teeth are prepared to receive said appliance.
- (iii) Removable Complete and Partial Dentures - Total cost for removable complete and partial dentures shall be incurred on the date that the final impressions are taken for said appliance.
- (iv) Endodontics - Total cost for endodontic treatment shall be incurred when the pulp chamber of the tooth is opened.
- (v) Implant Prosthetics - Total cost for the prosthetic portion of an implant shall be incurred on the date the final impression is taken for said appliance.

V. Coordination of Benefits (Dual Coverage)

The Coordination of Benefits provision is designed to provide maximum coverage, but not to exceed 100% of the total fee for a given service. In the event that any Eligible Person is entitled to benefits under any other health care program, the following Coordination of Benefits provisions shall determine the sequence and extent of payment. Other health care programs may include any other sponsored plan or group insurance plan. No payment will be made by Delta Dental for services that are covered expenses, in whole or in part, by a medical plan.

- A. Except for services resulting from an accident, as described below, Delta Dental is the primary payor for all covered oral surgery procedures for eligible participants in the medical HMO program. Balances may be sent to the medical carrier for consideration. The medical carrier is the primary payor for all covered oral surgery procedures for eligible participants enrolled in the medical POS program. Delta Dental will not consider balances for payment when the medical carrier is the primary payor for oral surgery procedures. The medical carrier is the primary payor for both the HMO and POS programs when dental treatment is the result of an accident. Delta Dental will consider balances for payment when the medical carrier is the primary payor for treatment that is the result of an accident.
- B. When an Eligible Person is covered under another health care program, the following rules shall be followed to establish the order of determining liability.
 - 1. When only one plan has a Coordination of Benefits provision, the plan without such provision shall determine its benefits first.
 - 2. The plan covering an Eligible Person solely as an employee shall determine its benefits before the plan that covers the Eligible Person solely as a Dependent.
 - 3. The plan covering the Eligible Person solely as a Dependent of the parent whose birth date occurs earlier in a calendar year shall determine its benefits before the plan covering the Eligible Person solely as a Dependent of the parent whose birth date occurs later in a calendar year (i Birthday Rule). A parent's year of birth is not relevant. If both parents have the same birth date (month and day) the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time. If the other health care program does not use the Birthday Rule, then that plan's provisions will determine the order of liability.
 - 4. If paragraphs 2 and 3 above do not establish an order of benefit determination, the benefits of the plan that has covered the Eligible Person for the longer period of time shall be determined first.
 - 5. The order of payment for the claims of a Dependent child of divorced or legally separated parents will be as follows:
 - a. the plan of the parent with custody;
 - b. the plan of the spouse of the parent with custody (step-parent);
 - c. the plan of the parent without custody.

However, when the parents are separated or divorced and there is a court decree that establishes financial responsibility with respect to the child, the benefits of the plan that cover the child as a Dependent of the parent with financial responsibility shall be determined before the benefits of any other plan that covers the child as a Dependent.

- 6. When Delta Dental is the first to determine its benefits under the foregoing, benefits hereunder shall be paid without regard to Coverage under any other plan. When Delta Dental is not the first to determine its benefits and there are remaining expenses of the type allowable, Delta Dental will pay only the amount by which its benefits exceed the amount of benefits payable under the other plan up to the amount Delta Dental would have paid without regard to the payment by the other plan or the amount of such remaining expenses, whichever is less. In other words, the combined payment of both plans will not exceed the total cost of the service.

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- a. Delta Dental may use reasonable efforts to determine the existence of other benefit programs but shall be under no obligation to do so.
 - b. The Eligible Person is required to furnish Delta Dental with information relative to any other health care program in order to determine liability.
 7. For the purposes of determining the applicability and implementing the terms of this provision in the Agreement, Delta Dental may release information to, or obtain it from, any party with a legitimate interest in such information, without consent or notice. Delta Dental shall be free from any liability that might arise in relation to such action.
 8. Multiple Coverage: When benefits are coordinated with another Delta Dental plan, or any other plan providing dental benefits, time limitations and frequency of service limitations will not change. Coverages for services, for which a specified number are provided per a specified time period, shall not be added together to provide more than the number of services specified per time period under this plan. For example, if each plan covers one prophylaxis (cleaning) in a six month period, the combined coverages will still only cover one prophylaxis in any six month period. If such a service is covered under this plan, but has been paid for, whether in full or part, by another plan, such service will still be counted toward the maximum number of such services allowed per period under this plan.
 9. Right of Recovery: Delta Dental has the right to recover from the payee excess benefit payments.

VI. General Claims Inquiry

After a claim is submitted by your Dentist and processed by Delta Dental, you will be sent a Notification of Benefits form. This notice will explain the benefits that were paid on your behalf, let you know if any services are denied, and give you the reason(s) for the denial.

If you have any questions regarding your benefits, you may call Delta Dental for an explanation at 603-223-1234. The toll-free number is 800-832-5700. You will be connected directly to our Customer Service Department.

The Customer Service Representative will need to know the claim number that is located on your Notification of Benefits form, or if that information is not available, the Subscriber's identification number. This will enable a quick response to your inquiry.

VII. Disputed Claims Procedure

After you have followed the General Claims Inquiry procedure and have reason to believe your benefit determination was not in accordance with the Agreement between Delta Dental and your group, you have the option of using Delta Dental's Disputed Claims Procedure. This may be requested within six (6) months of the issuing of Delta Dental's original Notification of Benefits. Your written request for a review of your claim should be personally delivered or mailed certified mail, return receipt requested, to the Vice President, Professional Relations, Northeast Delta Dental, One Delta Drive, PO Box 2002, Concord, New Hampshire, 03302-2002.

Your request for a review of your claim should reference the claim(s) in question and state your name and address, the reasons you think the denial should be evaluated, and any additional materials you wish to present.

The Vice President, Professional Relations, or his designee may request additional documents as necessary to make such a review and will promptly review your claim. If the claim is wholly or partially denied, you will be furnished with a notice of the decision within forty-five (45) days after receipt of the disputed claim. The written notice will include:

1. the specific reason(s) for denial, and
2. the specific reference to the provision upon which the denial is based.

If your request for review results in an additional payment, it will be made within fifteen (15) working days of the response by the Vice President, Professional Relations.

If you do not receive notice within the forty-five-day (45-day) period, the claim is considered denied so that you may proceed to the Disputed Claims Review Procedure.

If you have any problem securing a review of your claim, contact your group for assistance.

VIII. Disputed Claims Review Procedure

The Disputed Claims Review Procedure allows you to request a review from Delta Dental's Disputed Claims Review Committee after receipt of written notification of the denial of your claim by the Vice President, Professional Relations. The Review Committee is composed of Participating Dentists, non-Dentist members of the Board of Directors, and representatives of group purchasers/groups.

You or your duly authorized representative may appeal to the Review Committee by filing a request for review before the final appeal date set forth in the notice denying the claim by the Vice President, Professional Relations, or, if no date is given, within six (6) months of the notice. Your written request should be sent certified mail, return receipt requested, to the Review Committee at the Northeast Delta Dental address noted previously. It must state specifically the reasons for requesting a review. It should contain issues, comments, and supporting materials stating why you believe the Delta Dental Vice President, Professional Relations' response was incorrect. Not later than thirty (30) days after receipt of your request, the Review Committee will render its written decision, including specific reasons for the decision.

In addition, or as an alternative to the written request procedure, you may request a hearing from the Review Committee to consider matters raised in your appeal. At the hearing, you are entitled to representation by legal counsel or other duly authorized representatives, to request the presence of a stenographer to transcribe the hearing, to present evidence, to request the testimony of witnesses, and to cross-examine witnesses. You or your representative may review the Agreement and related pertinent documents. The hearing will be scheduled with prompt written notice to you not later than thirty (30) days after your request. A decision will be rendered not later than thirty (30) days after the hearing. The decision of the Review Committee will be in writing and will include specific reasons for the decision.

IX. Termination

Benefit entitlement may be automatically terminated:

1. On the last day of the month for which you have failed to make a required payment.

X. Continuation and Conversion of Benefits

If your or your Eligible Dependent's coverage under the program terminates for any reason, including at the end of any coverage continuation period, you and your Eligible Dependent(s) will have no right to convert to an individual dental plan. The benefits provided under the program are group benefits and are not convertible to individual plans or coverages.

State and Federal Law Rights to Continue Coverage

Upon termination of coverage under this dental benefits plan, former Subscribers and/or Eligible Dependents may be eligible, under federal (COBRA) and/or state (New Hampshire RSA 415:18 (g)(1)) statutes, to continue group coverage benefits, depending upon certain conditions contained in those laws. If a former Subscriber or Eligible Dependent elects to continue coverage under either the federal or state statute, if either is applicable, the group under which benefits were formerly provided will be responsible to collect the applicable premium from the persons electing coverage. The applicable state or federal law will govern administration of the continuation coverage. Rights under those statutes are provided below:

A. Rights Under the Federal Statute (COBRA)(if applicable):

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage under a group health plan would otherwise end. For simplicity, your group dental plan is referred to in this Notice as the "Plan." You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the premium for your continuation coverage. At the end of the maximum coverage period (described below), there is no individual conversion dental plan available under the Plan. This Notice provides a brief overview of your rights and obligations under current law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly. **The COBRA law also gives continuation rights to retirees and their dependents under this plan.**

Both you (the retiree) and your spouse should read this summary carefully and keep it with your records!

Qualifying Events

If you are an **employee** of the Employer and are covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two "qualifying events":

1. Termination of your employment (for reasons other than gross misconduct).
2. Reduction in the hours of your employment.

If you are the **spouse** of an employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

1. The death of your spouse.
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the Employer.
3. Divorce or legal separation from your spouse (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal

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- separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
4. Your spouse becomes entitled to Medicare benefits.

In the case of a ***dependent child*** of an employee covered by the Plan, he or she has the right to elect continuation coverage if group dental coverage under the Plan is lost because of any of the following five "qualifying events":

1. The death of the employee parent.
2. The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in the employee parent's hours of employment with the Employer.
3. Parents' divorce or legal separation.
4. The employee parent becomes entitled to Medicare benefits.
5. The dependent ceases to be a "dependent child" under the Plan.

Your IMPORTANT Notice Obligations

If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation or the child's losing dependent status under the Plan, then under the COBRA statute, you (the employee) or your spouse or dependent has the responsibility to notify the Plan Administrator of the divorce, legal separation, or the child's losing dependent status. You or your spouse or dependent must provide this notice no later than 60 days after the date coverage terminates under the Plan (see this summary plan description for details regarding when Plan coverage terminates.) *If you or your spouse or dependent fails to provide this notice to the Plan Administrator during this 60-day notice period, any spouse or dependent child who loses coverage will NOT be offered the option to elect continuation coverage.* Furthermore, if you or your spouse or dependent fails to provide this notice to the Plan Administrator, and if any claims are mistakenly paid for expenses incurred after the date coverage is supposed to terminate upon the divorce, legal separation, or a child's losing dependent status, then you, your spouse and dependent children will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is timely provided with notice of a divorce, legal separation, or a child's losing dependent status that has caused a loss of coverage, then the Plan Administrator will notify the affected family member of the right to elect continuation coverage (but only to the extent that the Plan Administrator has been notified in writing of the affected family member's current mailing address--see "YOU MUST NOTIFY US..." paragraph below).

You (the employee) and your spouse and dependent children will also be notified of the right to elect continuation coverage upon the following events that result in a loss in coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, or death, or the employee's becoming entitled to Medicare.

Election Procedures

You (the employee) and/or spouse and dependent children must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. *If you or your spouse and dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.* A COBRA election mailed to the Plan Administrator is considered to be made on the date of the mailing.

You (the employee) and/or spouse and dependent children may elect continuation coverage for all qualifying family members. You, your spouse and dependent children each have an independent right to elect continuation coverage. Thus, a spouse or dependent child may elect continuation coverage even if the covered employee does not (or is not deemed to) elect it.

You (the employee) and/or your spouse and dependent children may elect continuation coverage even if covered

under another employer-sponsored group dental plan or entitled to Medicare.

Type of Coverage

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse or dependent children had on the day before the qualifying event. Therefore, an employee, spouse or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event such as a divorce. If the coverage is modified for similarly situated employees or their spouses or dependent children, then COBRA coverage will be modified in the same way.

If the Employer maintains more than one group health plan, you (or your spouse or dependent children) may elect COBRA coverage under any one or more of those plans in which you have coverage. For example, if you are covered under three separate Employer plans, a medical plan, a dental plan, and a vision plan, you could elect COBRA coverage under the medical plan and decline coverage under either or both of the dental and vision plans. But if the Employer maintains one consolidated group health plan (for example, one that provides medical, dental, and vision benefits under a single plan), you must elect or decline COBRA coverage for the plan as a whole.

COBRA Premiums You Must Pay

The premium payments for the "initial premium months" must be paid for you (the employee) and for any spouse or dependent child by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made.

Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until that month's premium is paid within the 45-day period after the election of continuation coverage is made.

All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is considered to be made on the date it is sent. If you don't make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1st of the month.

Maximum Coverage Periods

The maximum duration for COBRA coverage is described below. COBRA can be cut off before the maximum period expires in certain situations described later under the heading "Termination of COBRA Before the End of the Maximum Coverage Period."

36 Months. If you (the spouse or dependent child) lose group dental coverage because of the employee's death, divorce, legal separation, or the employee's becoming entitled to Medicare, or because you lose your status as a dependent under the Plan, then the maximum coverage period (for spouse and dependent child) is three years from the date of the qualifying event.

18 Months. If you (the employee, spouse or dependent child) lose group dental coverage because of the employee's termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period (for the employee, spouse and dependent child) is 18 months from the date of termination or reduction in hours. There are three exceptions:

- If an employee or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of the termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to

the Plan Administrator within both the 18-month coverage period and 60 days after the date of the determination.

- If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child (for example, the employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a spouse or dependent child) becomes three years from the date of the initial termination or reduction in hours.
- If the qualifying event occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period (for the spouse and dependent child) ends three years from the date the employee became entitled to Medicare.

Children Born to or Placed for Adoption With the Covered Employee During COBRA Period

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered a qualified beneficiary provided that, where the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The covered employee or other guardian has the right to elect continuation coverage for the child, provided that the child satisfies the otherwise applicable plan eligibility requirements (for example, regarding age). The covered employee or a family member must notify the Plan Administrator within 30 days of the birth, adoption or placement for adoption to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the employee. (The 30-day grace period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption.) *If the covered employee or family member fails to so notify the Plan Administrator in a timely fashion, then the covered employee will NOT be offered the option to elect COBRA coverage for the child.*

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add coverage for dependents if such person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under "Children Born to or Placed for Adoption With the Covered Employee After the Qualifying Event," dependents who are added under HIPAA's special enrollment rights do not become qualified beneficiaries - their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them.

Termination of COBRA Before the End of Maximum Coverage Period

Continuation coverage of the employee, spouse and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs.

1. The Employer no longer provides group health coverage to any of its employees.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (the employee, spouse or dependent child) become covered under another group dental plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group dental plan. (Note that under HIPAA, an exclusion or limitation of the other group dental plan might not apply at all to the qualified beneficiary depending on the length of his or her creditable dental plan coverage prior to enrolling in the

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- other group dental plan.)
4. After electing COBRA coverage, you (the employee, spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
 5. You (the employee, spouse or dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
 6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

You Must Notify Us About Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes

If your or your spouse's address changes, you *must* promptly notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important COBRA and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or dependent must promptly notify the Plan Administrator in writing (such notification is necessary to protect COBRA rights for your spouse and dependent children). In addition, you must notify us if a disabled employee or family member is determined to be no longer disabled.

Plan Administrator

The Employer is the Plan Administrator. All notices and other communications regarding the Plan and regarding COBRA must be directed to the individual who is acting on behalf of the Plan Administrator.

For More Information

If you, your spouse or dependent children have any questions about this notice or COBRA, please contact the Plan Administrator. Also, please contact the Plan Administrator if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions and limitations.

B. New Hampshire Continuation Statute (RSA 415:18(g)(1) (if applicable):

Whenever any individual becomes ineligible for continued participation in the group dental plan for any reason including death, except dismissal for gross misconduct, the benefits of such group dental plan shall be available at the same group rate to the individual, the surviving spouse and the dependents covered by the group plan, for an extension period of:

1. 18 months; or
2. 29 months in the case of an individual who is determined, under Title II or XVI of the Social Security Act to have been disabled within the first 60 days of the date such individual becomes ineligible for continued participation in the plan; or
3. Except when the widow, widower, divorced spouse, or legally separated spouse of a covered employee is 55 years of age or older, 36 months in the case of:
 - (i) the death of the covered employee;
 - (ii) the divorce or the legal separation of the covered employee from the employee's spouse;
 - (iii) the covered employee's becoming entitled to benefits under Title XVIII of the Social Security Act or within the 18-month continuation in subparagraph (g)(1)(A);
 - (iv) a dependent child ceasing to be a dependent child; or

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- (v) coverage reduction or termination that takes place within one year of the date the employer files for protection under the bankruptcy provisions of Title 11 of the United States Code.
4. When the surviving spouse, divorced spouse, or legally separated spouse of a covered employee is 55 years of age or older, in the case of the death of the covered employee; or, the divorce or the legal separation of the covered employee from the employee's spouse, then the extension period shall continue until the surviving spouse, divorced spouse, or legally separated spouse becomes eligible for participation in another employer-based group dental plan or becomes eligible for Medicare.
5. Extension coverage need not be provided beyond:
- (i) the first day of the month following the date the individual becomes eligible for benefits under another group plan;
 - (ii) the date of the first Medicare open enrollment period following the date the individual became ineligible for continued participation under the group plan;
 - (iii) the date on which the group plan terminates; or
 - (iv) the date on which coverage ceases because of a failure to make timely payment of premium as required; however, the payment of any premium shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to the plan.
6. The individual, surviving spouse, divorced spouse, legally separated spouse, or dependent shall elect to continue the participation in the group dental plan according to rules of the New Hampshire Insurance Commissioner. The individual, surviving spouse, or dependent shall be responsible for payment of premiums which may include an administrative fee not to exceed 2 percent of the monthly premium to the employer or policyholder throughout the extension period. Any divorced spouse or legally separated spouse who is responsible for making a portion of or full payment to the employer shall notify the employer and Delta Dental, in writing within 30 days of the decree of divorce or separation, that coverage under this subparagraph is requested. Any employee who is responsible for making a portion of or full payment to the employer shall likewise notify the employer and Delta Dental, in writing within 30 days of the decree of divorce or separation, that coverage under this subparagraph is requested. The employer shall have the right to terminate coverage for a former dependent spouse who is receiving coverage under this subparagraph if any payment for the coverage is not received from the former dependent spouse within 30 days of the date the premium payments are due. If any payment for the coverage for which the employee is responsible is not received from the employee within 30 days of the date the premium payments are due, the employer shall have the right to terminate coverage for a former dependent spouse; however, no such termination shall occur without 30 days' prior notice to the former dependent spouse, during which time the former dependent spouse shall be given an opportunity to make the payments due or to secure payment from the employee. Upon termination of the extension period, the member, surviving spouse, divorced spouse, legally separated spouse, or dependent shall be entitled to exercise any option which is provided in the group dental plan to elect a converted policy. After timely receipt of the premium payment from the individual, surviving spouse, divorced spouse, legally separated spouse, or dependent, if the employer fails to make payments to Delta Dental, with the result that coverage is terminated, the employer shall be liable for benefits to the same extent as Delta Dental would have been liable if coverage had not been terminated.

XI. General Conditions

Change of Status:

The Subscriber shall notify their group of any event causing a change in the status of an Eligible Person. Events that can affect status include, but are not limited to, marriage, birth, death, divorce, etc.

Assignment:

Benefits of Eligible Persons are personal and cannot be transferred.

Right of Recovery:

Delta Dental will succeed to the Eligible Person's right of recovery against any third person or organization that may be liable. The Eligible Person will authorize Delta Dental to do whatever is necessary to secure such rights.

Doctor-Patient Relationship:

The Eligible Person has the freedom to choose any Dentist. Dentists rendering service under the Agreement are independent contractors and will maintain the traditional doctor-patient relationship. The Dentist will be solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment:

If an Eligible Dependent loses eligibility while receiving dental treatment, only covered services received while eligible will be considered for payment.

Maintaining Your Privacy:

Northeast Delta Dental has always respected and carefully preserved the privacy and confidentiality of Subscribers and their Dependents. As part of that protection, compliance with all state and federal laws regarding privacy of personal and health information is maintained. For a copy of Northeast Delta Dental's Notice of Privacy Practices, which describes in detail our respective privacy practices, or if you have any questions about the privacy of your health information, please contact:

Privacy Officer
Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
(800) 537-1715

XII. Questions and Answers

1. May I Choose Any Dentist?

Yes. You are free to choose any Dentist as defined in Section I., Definitions.

2. Will Delta Dental Make Payment Directly to The Dentist or Will I Receive Payment?

If the Dentist is participating, Delta Dental will make payment directly to the Dentist. If the Dentist does not participate, then payment for services rendered will be made directly to you.

3. What Difference does it make if I Go to A Participating Dentist or A Non-Participating Dentist?

Delta Dental does not restrict you from visiting any Dentist. However, if you go to a Participating Dentist, reimbursement may result in a lower Co-payment for you. Delta Dental will pay to such Participating Dentist the applicable Selected Co-payment percentage of the allowable fee (as such fees are filed with and/or accepted by Delta Dental), or the billed fee, whichever is less. Such payment, together with the Subscriber's Co-payment, shall discharge in full the claim of such a Participating Dentist for the Care provided.

If you are treated by a Non-Participating Dentist, Delta Dental will make payment directly to you on the basis of the Dentist's fee up to the maximum amount allowed Non-Participating Dentists. It will be your responsibility to make full payment to the Dentist.

4. When Does My Dental Coverage Begin?

Refer to Eligibility Period, in the Outline of Benefits. Only dental services received after you become eligible will be covered.

5. How much of the Dental Bill Do I Pay?

You are responsible for the amount shown on your Notification of Benefits form, which will include any charges for optional treatment or specific exclusions of your program. Your Dentist may request your Co-payment, Deductible, etc., at the time services are rendered.

6. Am I Covered for All Dental Services?

Not necessarily. Your Coverage is described in the Outline of Benefits. These covered benefits are governed by the Exclusions, Limitations, and Delta Dental's current Processing Policies.

7. What If My Spouse Is Covered By Another Dental Plan?

You may be entitled to as much as (but not more than) 100% of your Dentist's charges for covered benefits. It is important that you inform your Dentist of any dual coverage so that the proper claim filing procedures may be followed.

8. Is It Necessary for Me to Have My Dentist Get a Predetermination for My Dental Services?

Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it is not required, Predetermination helps avoid any potential confusion regarding Delta Dental's payment and your financial obligation to the Dentist.

Exceptional Service Is Our Guarantee

Northeast Delta Dental is committed to providing exceptional service to all of our customers. In fact, we have established the region's first comprehensive guarantee program called ***Guarantee of Service ExcellenceSM***

As a Subscriber, you are very important to us. To emphasize our commitment, we guarantee our service in the following seven major areas.

- Smooth implementation to Northeast Delta Dental
- Exceptional customer service
- Quick processing of claims
- No inappropriate billing by Participating Dentists
- Accurate and quick turnaround of identifications cards
- Timely employee booklets
- Marketing service contacts

For example, if a Dentist charges for more than the appropriate Co-payments at the time of service, it is important that we hear from you so that we can resolve it quickly. If you call us with an inquiry, we promise to answer your question immediately or contact you to update our progress within 24 hours. Accurate ID cards and employee booklets will be mailed, generally to your employer, within 15 days of receiving a request, and we're committed to processing 90% of each group's yearly claims within 15 days.

Quality performance has always been an essential component of customer satisfaction. When an area is identified where we did not fulfill our promise, your feedback enables us to enhance our process and, therefore, serve you better. If you are not satisfied with our service, please let us know.

If you would like further information about this program, please call us at 603-223-1234.

Customer Service
603-223-1234
800-832-5700
TTY/Hearing Impaired
800-332-5905

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